Form 112
Medical Fee Dispute
Revised 8-15-96

DEPARTMENT OF WORKERS CLAIMS
1270 LOUISVILLE ROAD
FRANKFORT, KENTUCKY 40601
Claim No. _____

MEDICAL FEE DISPUTE

Movant:

_____
Name

_____
Street Address

_____
City, State, Zip Code

vs.

Respondent:

_____
Name

_____
Street Address

_____
City, State, Zip Code

* *

Patient:

_____
Name & Social Security Number

_____ _____
Street Address Date of Injury

_____
City, State, Zip Code

Employer:

_____
Name

_____
Street Address

_____
City. State, Zip Code

Medical Payment Obligor:

_____
Name

_____
Street Address

_____
City, State, Zip Code

Counsel for Movant:

_____
Name

_____
Street Address

_____
City, State, Zip Code

Medical Provider:

_____
Name

_____
Street Address

_____
City, State, Zip Code

Medical Provider:

_____
Name

_____
Street Address

_____
City. State, Zip Code

Medical Provider:

_____
Name

_____
Street Address

_____
City, State, Zip Code

Medical Provider:

_____
Name

_____
Street Address

_____
City, State, Zip Code

* *

Comes the movant and requests resolution of a medical fee dispute, and states as follows:

① A workers compensation claim has _____ has not _____ been filed with the Department of Workers Claims.

② Utilization review and medical bill audit have been completed. A copy of the final utilization review decision with supporting medical opinions is attached. Yes____ No___

Note: If utilization review is required by 803 KAR 25:190, no Medical Fee Dispute may be filed prior to exhaustion of that process.

③ Utilization review is not required by 803 KAR 25:190 in this claim because (state specific reason):

_____

_____

④ The date on which each disputed statement for services was first received by the payment obligor or any agent thereof is _____, 19____.

⑤ Copies of all disputed statements for services are attached hereto, including all required documentation. Yes _____ No _____

⑥ The nature of this dispute can be briefly described as follows: (Please include all facts necessary for relief sought and attach copies of any supporting medical documentation).

_____

_____

_____

_____

This information is true and accurate according to my knowledge and belief.

_____

Movant's Signature

Subscribed and sworn to before me this _____ day of _____, 19_____

_____

Notary Public Signature

My Commission Expires: _____

Note: The respondent and all other parties have 20 days in which to file a response pursuant to 803 KAR 25:012. Copies of responses must be delivered to the Commissioner of the Department of Workers Claims and to all parties.

Certificate of Service

As required by 803 KAR 25:012, copies must be served on all parties, including the employee, employer, medical payment obligor, and the medical provider(s). I certify that true copies of this form and all attachments have been deposited in the United States mail today to the Commissioner of the Department of Workers Claims, 1270 Louisville Rd, Frankfort, Kentucky, 40601, and to the following individuals or entities: (Please list names and addresses)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Date:_____ _____

Movant's Signature

NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.